STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	A. BUILDING 00			COMPLETED	
		15G641	- 1	B. WING 09/08/2			011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER				REEN STREET			
PEAK CO	DMMUNITY SERVIC	CES INC			ISPORT, IN46947			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	-E	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
W0000								
	This visit was for	r a fundamental annual	W	0000				
	recertification an	d state licensure survey.						
	100111110011011							
	Datas of Curvey	Santambar 6 7 and 9						
		September 6, 7, and 8,						
	2011.							
	Provider Number	r: 15G641						
	Facility Number:	001218						
	AIM Number: 1	00235390						
	Surveyor: Tracy	Brumbaugh, Medical						
		•						
	Surveyor III/QM	RP.						
	-	deral deficiencies also						
	reflect state findi	ngs in accordance with						
	431 IAC 1.1.							
	Quality Review of	completed 9/8/11 by Ruth						
		dical Surveyor III.						
W0137	The facility must e	nsure the rights of all				l		
W0137		, the facility must ensure						
	that clients have th	ne right to retain and use						
		nal possessions and						
	clothing.						ļ !	
	Based on observa	ation, record review and	W	0137			10/08/2011	
	interview, the fac	cility failed for 3 of 3			Peak Community Services is			
	clients who smok	xed, (clients #3, #4, and			committed to ensuring that cl	ients		
		/ / / / / /						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Event ID:

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Facility ID:

001218

If continuation sheet

li ´		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G641	A. BUI	LDING	00	09/08/2	
130041		B. WIN			09/00/2	011	
NAME OF	PROVIDER OR SUPPLIE	3		1	ADDRESS, CITY, STATE, ZIP CODE REEN STREET		
PEAK C	OMMUNITY SERVI	CES INC		1	ISPORT, IN46947		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 '	garettes they purchased			have the right to retain and u appropriate personal posses		
	were available to	them.			and clothing.	310113	
					A new procedure has been p	ut	
	Findings include	: :			into place by the SGL Manag	jer	
					and Coordinator regarding		
	On 9-7-11 from	6:00 a.m. until 7:05 a.m.			cigarette storage. Each clier a lock box in his room. Each		
	an observation a	t the home of clients #3,			client is in charge of his own		
	#4, and #6 was c	conducted. At 6:35 a.m.			This is in place for all clients		
	client #6 asked d	lirect care staff (DCS) #4			the home.		
	for another pack	of cigarettes. DCS #4			SGL Coordinator will monitor procedure to assure it is	this	
	asked client #6 v	why he needed more and			maintained as intended and		
	he indicated it w	as so he would have			clients have no rights violate	d.	
	enough at work.	DCS #4 got a set of keys			Currently, no other group ho		
	and unlocked the	e closet door and gave			has clients who smoke. Sho		
	client #6 a pack	of cigarettes.			they begin smoking, a lock b system will be put in place fo		
					client.	1 1113	
	At 6:40 a.m. on	9-7-11 an interview with			Person Responsible:		
	DCS #4 indicate	d clients #3, #4, and #6			Bridget Neal, Residential		
	all purchased the	eir own cigarettes and			Coordinator Kris Myers, SGL Manager		
	they were kept lo	ocked up.			Completion Date: 10-8-11		
		-			,		
	On 9-7-11 at 11:	35 a.m. a review of client					
	#3's Comprehens	sive Functional					
	Assessment (CF.	A) dated 7-13-11 did not					
	indicate he had a	need for his cigarettes to					
	be locked up.	-					
	On 9-7-11 at 11:	45 a.m. a review of client					
	#4's CFA dated 6	6-7-11 did not indicate he					
	had a need for hi	is cigarettes to be locked					
	up.	-					
	-						
	On 9-7-11 at 11:	50 a.m. a review of client					
		5-19-11 did not indicate					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G641	B. WING		09/08/2011	
NAME OF D	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		1711 TI	REEN STREET		
	DMMUNITY SERVIC			NSPORT, IN46947		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	
IAG		LSC IDENTIFYING INFORMATION)	TAG	BLI ICILINE I)	DATE	
		r his cigarettes to be				
	locked up.					
		5 a.m. an interview with				
	_	Services Manager				
	_	arettes should be kept by				
	the individuals w	vith each client having				
	their own key to	their cigarette lock box.				
	1.1-3-2(a)					
W0227	The individual prod	gram plan states the	1			
W 0227	The individual program plan states the specific objectives necessary to meet the					
		ent's needs, as identified by the				
	comprehensive assessment required by					
	paragraph (c)(3) o		1			
	Based on record review and interview, the		W0227	W227	10/08/2011	
	_	1 of 3 sampled clients		Peak Community Services is committed to ensuring the	,	
	(client #2) to ens	ure he had a toileting		individual program plan state	es the	
	goal included in	his Individualized		specific objectives necessary		
	Support Plan (IS	P).		meet the client's needs, as		
	` ` `			identified by the comprehens	sive	
	Findings include			assessment required by	:	
	<u> </u>		1	paragraph (c) (3) of this sect For client #2, there is now a		
	On 9-7-11 at 9:30	0 a.m. a record review for		in place for toileting and a	9001	
		nducted. The D&E		restroom tracking sheet.		
		Evaluations) dated 4-09		To ensure that the deficient		
	` •	, , , , , , , , , , , , , , , , , , ,	1	practice does not reoccur the)	
		‡2 had a diagnosis of		SGL Manager will anot monitor all		
	_	ence. His ISP dated		Manager will spot monitor all Comprehensive Functional		
	8-30-11 did not i			Assessments and goals to a	ssure	
	goal/objective to	assist him with his		all areas of need are address		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
15G641		A. BUII	LDING	00	09/08/2		
		130041	B. WIN		DDDEGG GWY GWATE GID GODE	09/00/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
PEAK CO	OMMUNITY SERVIC	CES INC			SPORT, IN46947		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	for all group home clients in t	ho	DATE
	the Community S indicated client # incontinence duri	5 a.m. an interview with Services Manager 2 did have urinary ing the day and at night. d he had no goal to assist eting needs.			individual program plans ove next three months. Person Responsible: Kris Myers, QMRP Bridget Neal, Residential Coordinator Kris Myers, SGL Manager Completion Date: 10-08-11		
W0382	prepared for admir Based on observation interview, the fact clients (clients #1 who lived in the did not have access the open medicate. Findings include. On 9-6-11 from 5 medication admir At 5:15 p.m. direct observed to leave medications which Divalproex 500 r. Citalopram 20 m. Omeprazole 20 n.	except when being nistration. ation, record review, and cility failed for 6 of 6 1, #2, #3, #4, #5, and #6) home, to ensure clients ess to the medications in tion room.	W	0382	W382 Peak Community Services is committed to ensuring that all drugs and biologicals are kep locked except when being prepared for administration. A new procedure has been printo place for Residential statikeep the key to the medicine box on their person during the shift so it is not accessible to unauthorized persons. The Residential Coordinator spot check for this key procedure to be carried out correctly for three months on all shifts in the group home. All staff have already been trained on this procedure. The SGL Managwill spot check for this key procedure to be carried out correctly for the next three months in other group homes.	ut ff to lock eir will dure his	10/08/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G641 09/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1711 TREEN STREET PEAK COMMUNITY SERVICES INC LOGANSPORT, IN46947 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE room while she went to get herself a The current Supervised Group bottle of water from the garage. Client #3 Living Standard Operating was in the kitchen while his medications Procedure is for all labeled remained out on the counter in the laundry prescription medications transported to the Day Service room. Clients #1, #2, #3, #4, #5, and #6 program by residential staff, so were all home and had access to the the medication will not sit in an medications. unlocked location at any time. The medications that need On 9-7-11 from 6:05 a.m. until 6:20 a.m. delivered to Day Program will be taken out medication administration was observed. of the group home's locked At 6:15 a.m. direct care staff #4 was storage area and kept on the observed to place client #6's Tramadol 50 Residential staff person until they mg for pain in a bag on the counter. At are released to the Day Service staff. Upon receipt of the 6:30 a.m. the Tramadol 50 mg continued medications, the Day Service to be in the bag unsecured. At 6:45 a.m. staff will place the medications the Tramodol for client #6 was still into the Day Service locked medication storage area. All staff unsecured in the bag on the counter. At have been retrained on these 7:00 a.m. the bag with the Tramodol for procedures. client #6 was moved to the kitchen table The Residential Coordinator will by direct care staff #4. Clients #4 and #6 monitor the procedure of sat at the table with the unsecured residential staff transporting Clients #3 and #6's medications medication. Clients #1, #2, #3, #4, #5, to the Day Service Program by and #6 were all home and had access to spot checking for one month. the medications. The SGL Manager will spot check the morning storage procedure of Residential staff turning over the On 9-7-11 at 10:30 a.m. a record review medications to Day Service staff of the facility's Medication Administration and locking the medication in the Policy (no date available) indicated Day Service locked storage area medications in the group home were to be for two months. Bridget Neal, Residential maintained under proper conditions of Coordinator security. Kris Myers, SGL Manager Completion Date: 10-08-11 On 9-7-11 at 9:45 a.m. an interview with the Community Services Manager

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPI		LETED	
15G641		B. WING		09/08/2	2011	
				EET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER		I	1 TREEN STREET		
PEAK CO	DMMUNITY SERVIO	CES INC		GANSPORT, IN46947		
(X4) ID	CHMMADVC	TATEMENT OF DEFICIENCIES	ID	<u>,</u>		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD		COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
		tions should kept locked	1110			5.112
		-				
	until they are go	ing to be administered.				
	1.1-3-6(a)					
11/02/02	Only outborized n	oracna may have access to				
W0383	the keys to the dru	ersons may have access to				
	·	-	11/02/02	W383		10/00/2011
		ation and interview, the	W0383	Peak Community Service	e ie	10/08/2011
	•	6 of 6 clients (clients #1,		committed to only author		
	#2, #3, #4, #5, ar	nd #6) who lived in the		persons having access to		
	home, to ensure	only authorized persons		keys to the drug storage	area.	
	had access to the	keys to the drug storage		A new procedure has bee		
	area.			into place for Residential		
				keep the key to the medi		
	Findings include			box on their person durin shift so they are not acce	•	
	1 1114111185 11141444	•		unauthorized persons.	SSIDIC IO	
	On 9-6-11 from (3:20 p.m. until 5:45 p.m.		The Residential Coordina	tor will	
		t the home of clients #1,		spot check for this key pr		
		· ·		to be carried out correctly		
		nd #6 was conducted. At		three months on all shifts		
	•	dication keys were		have already been traine	on this	
	observed to lay of			new procedure. The SGL Manager will sp	ot check	
		y/medication room with		for this key procedure to		
	access to anyone	who walked by. At 5:05		carried out correctly for the		
	p.m. direct care s	staff (DCS) #1 was		three months in all other		
	observed to get t	he keys from the shelf in		homes, also.		
	_	m and assist clients #3		Bridget Neal, Residential		
		medications. At 5:15		Coordinator Kris Myors, SCI, Manage	r	
		s observed to leave the		Kris Myers, SGL Manage Completion Date: 10-08-		
	p.m. DCS #1 wa	s obscived to leave the		Completion Date: 10-00-	1.1	1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G641			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE : COMPL		
		B. WIN			09/08/2	011	
NAME OF PROVIDER OR SUPPLIER			<u> </u>	1	ADDRESS, CITY, STATE, ZIP CODE	•	
DEAKO		OFC INC		1	REEN STREET		
	OMMUNITY SERVI			L	ISPORT, IN46947		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
1710	 	om the medication closet		1110			DITTE
	1 '	et herself a bottle of					
	1	o.m. DCS #1 put the keys					
	1 -	f in the unlocked room.					
		House Manager assisted					
		s medications. She also					
		get the keys off the shelf					
		e medication closet. At					
		use manager put the keys					
	1 -	f in the unlocked room for					
	anyone who walked by to have access to						
	the medication closet keys.						
	On 9-7-11 from	6:00 a.m. until 7:05 a.m.					
	an observation a	t the home of clients #1,					
	#2, #3, #4. #5, an	nd #6 was conducted. At					
	6:00 a.m. the me	edication keys were					
	observed to lay	on the shelf in the					
	unlocked laundr	y/medication area with					
	1	who walked by. At 6:30					
	a.m. the keys we	ere on the shelf. At 6:45					
	1	ere on the shelf in the					
		At 7:00 a.m. direct care					
		keys from the shelf and					
		kitchen table as clients					
	#4 and #6 sat at	the table.					
	0.0611.653	0					
		0 p.m. an interview with					
		ger indicated the door					
	_	laundry/medication room					
	and not lock and	the door was kept open.					
	On 9-7-11 at 0.4	5 a.m. an interview with					
		Services Manager					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G641		(X2) MUI A. BUILI B. WING	DING	00	(X3) DATE S COMPL 09/08/2	ETED	
NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC				1711 TR	DDRESS, CITY, STATE, ZIP CODE EEN STREET SPORT, IN46947		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
W9999	_	rs were kept on the shelf om for anyone to have					
	Community Resi Persons with Dev rule was not met Governing Body (3) The resident the following cir- division by telep first business day summaries as rec This state rule is Based on record facility failed to (Bureau of Deve	ial provider shall report cumstances to the hone no later than the followed by written quested by the division. not met as evidence by: review and interview the report 4 of 10 BDDS lopmental Disabilities in a timely manner.	W9	W9999 Peak Community Services is committed to reporting BDDS (Bureau of Developmental Disabilities Services) reports in a timely manner by telephone no later than the first business day followed by written summaries as requested by the division. The offending staff person to this rule was verbally counseled on reporting procedures and timelines on BDDS Incident Reporting following this incident. To prevent this from reoccurrence the BDDS Incident Report Committee reviews each report submitted for the date of the incident and the date reported. If incidents are found to be reported late, the chair of the committee counsels the staff member who was responsible for reporting as to their obligation to report incidents within 24 hours of the		in a no lay es as this on ent. ence ort ed. If orted ee tho g as	10/08/2011

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I '		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G641	B. WIN	IG		09/08/2	011
NAME OF	PROVIDER OR SUPPLIER	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					REEN STREET		
PEAK C	OMMUNITY SERVI	CES INC		LOGAN	ISPORT, IN46947		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
TAG	On 9-6-11 at 11: facility's BDDS BDDS report wi 6-3-11 and a sub clients #1, #3, #4 were in a minor harm to vehicles #4, or #5. The re BDDS reports w On 9-7-11 at p.r. Retardation Prof reports were to b 2. 431 IAC 1.1- Community Res Persons with De rule was not met Resident Protect (3) The provide minimum, a burr record, a crimina references. This state rule is Based on record facility failed for	20 a.m. a review of the reports was conducted. A th an incident date of omit date of 6-6-11 for 4, and #5 indicated they car accident which caused but not to clients #1, #3, eview indicated the rere not filed within 1 day. In the Qualified Mental resional indicated BDDS of filed within 24 hours. 3-2(a) The following idential Facilities for velopmental Disabilities in shall obtain, as a reau of motor vehicles all history check and three that a conductive the review and interview the references.		TAG		vill II as s. I on for to ee ed to eed to	DATE
	1 manigo merade	···					
	Facility personn	el records were reviewed					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G641	A. BUILD B. WING		00 	COMPL 09/08/2	ETED
NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC			'	1711 TR	DDRESS, CITY, STATE, ZIP CODE REEN STREET SPORT, IN46947	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	on 9-7-11 at 9:00 personnel record record only inclu	o a.m. including the for staff #7. Staff #7's ided 2 references. 5 a.m. the Community or indicated 3 references		IAG			DATE